

PRINTED: 02/18/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2016
NAME OF PROVIDER OR SUPPLIER CHURCH HILL CARE & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 701 WEST MAIN BLVD CHURCH HILL, TN 37642			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on 2/16/16, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Don Davis

TITLE

Administrator

(X6) DATE

3/17/16

STATE FORM

6629

P8Z921

If continuation sheet 1 of 1